Health, Welfare Public Service

300 -57 C

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013076

FILED APR 20 1959

Registration District No. 137 Primary Registration District No. 3023 STATE FILE NUMBER Registrar's No. 94

1. PLACE OF DEATH
a. COUNTY: Henry
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clinton — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Wetzel Hospital — Length of stay in 1b: 4 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Clair
c. CITY OR TOWN: Osceola 0930 — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): Rt; 3 — Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: Anna Middle: V. Last: Jones

4. DATE OF DEATH: Month, Day, Year: Apr; 17, 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Dec; 12, 1880
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeping
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (City and state or country): St. Clair County Mo;
12. CITIZEN OF WHAT COUNTRY?: USA
13a. FATHER'S NAME: James Collins
13b. MOTHER'S MAIDEN NAME: Fannie Reser
14. NAME OF HUSBAND OR WIFE: Wm; Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: George Jones Osceola Missouri

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HYPOSTATIC PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): MYOCARDIAL DECOMPENSATION — UNKNOWN
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4222
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-12-59 to 4-16-59 and last saw her/him alive on 4-16-59
Death occurred at 4:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. L. Shipman, M.D.
22b. ADDRESS: Osceola, Mo.
22c. DATE SIGNED: 4-17-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/19/59
23c. NAME OF CEMETERY OR CREMATORY: Yeater Cemetery
23d. LOCATION (City, town, or county) (State): Osceola Missouri

24. FUNERAL DIRECTOR ADDRESS: Goodrich F. Home, Osceola Missouri
25. DATE RECD. BY LOCAL REG.: 4-17-59
26. REGISTRAR'S SIGNATURE: Mildred Bigum

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed J B Goodrich

Licensed Embalmer No 3038

P. O. Address Oneida

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.